

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2017
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SIGNATURE HEALTHCARE OF ELIZABETHON

1200 SPRUCE LANE
ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on 10/29/17, no deficiencies were cited under 1200-8-6 standards for nursing homes.	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6593

R2SP21

If continuation sheet 1 of 1